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Convention on the Elimination of All Forms of Discrimination against Women

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Committee on the Elimination of Discrimination against Women
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Item 5 of the provisional agenda*
Implementation of article 21 of the Convention on the Elimination of All Forms of Discrimination against Women

Report provided by specialized agencies of the United Nations on the Implementation of the Convention in areas falling within the scope of their activities

Note by the Secretary-General

Addendum

World Health Organization

1. On behalf of the Committee, on 18 October 2000, the Secretariat invited the World Health Organization (WHO) to submit to the Committee a report on information provided by States to WHO on the implementation of the Convention on the Elimination of All Forms of Discrimination against Women, in areas falling within the scope of its activities, which would supplement the information contained in the reports of the States parties to the Convention to be considered at the twenty-fifth session. The annex to the present note contains a country brief prepared by WHO.

2. Other information sought by the Committee referred to activities, programmes and policy decisions undertaken by WHO to promote the implementation of the Convention.

3. The report annexed hereto has been submitted in compliance with the Committee's request.

* CEDAW/C/2001/II/1.

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Annex

Report of the World Health Organization to the Committee on the Elimination of Discrimination against Women at its twenty-fifth session (July 2001)

GUYANA

Basic indicators

Guyana has a total population of 861,000 people consisting of 436,000 females and 425,000 males[1]. The ratio of women to men is 103:100[2]. Life expectancy at birth is 68 years for girls and 61 for boys[3]. Economically, the country falls in the middle-income category[4]. 36.2% of the population live in urban areas and the urban growth rate (1995-2000) was 2.9% per year[5].

Children

30 per cent of the population is under 15 years of age[6]. The infant mortality rate is significantly lower for girls (48 per thousand live births) than for boys (67 per thousand live births)[7]. Child mortality rate per 1,000 live births (under 5 years) was 79 in 1998, a reduction from 126 in 1960[8]. Immunisation coverage is good, ranging from 90 to 93 for DPT, polio, TB and measles[9]. The primary school enrolment ratio between girls and boys was 94 : 95 show no bias against girls[10].

140 children under 15 years of age were reported living with HIV/AIDS at the end of 1999. One thousand one hundred children had been orphaned by AIDS[11].

Adolescents

20% of the population are aged 10-19 years[12]. Very little published data was found on this age group including their health problems. Fifty-eight births were reported for every 1,000 females aged 15-19 in 1995-2000[13]. The proportion of 15-24 year-olds living with HIV/AIDS was not known.

Women

In 1998 the total fertility rate was 2.3 births per woman a significant decrease from 6.5 in 1960[14]. Contraceptive prevalence was not reported. In 1998 the maternal mortality ratio

was high at 190 per 100,000 live births although 95 per cent of pregnant women received some prenatal care and 95% of deliveries were reportedly attended by trained personnel[15].

HIV/AIDS is a growing problem, with an estimated 15,000 persons having been infected by the end of 1999. At that time, 4,900 women were reported with HIV/AIDS. In 1997, 44% of sex workers were reported HIV+[16].

Older/ Ageing women

7% of the population in 2000 were women aged 60 years and over and 6% were men. The ratio of women to men over 60 years was 125:100, rising to 150:100 after the age of 80[17]. No information was easily available on the mental or physical health needs of older/ ageing women.

Conclusion

Maternal mortality has been identified as an area in need of further investigation and action; the general paucity of data also needs to be addressed.

Comment

Useful analysis of the health situation of women in Guyana is complicated by the paucity of easily available data either specifically about women or about girls/ women as compared with boys/men.

In view of this the Committee might wish to ask about the Government's overall data collection, analysis and planning system including in the field of health including non reproductive health issues like cardio vascular disease and violence against women. Particular attention might be recommended to the situation of particularly vulnerable women and girls including elderly women and adolescent girls as well as women and girls of marginal groups. Availability of disaggregated data and regular gender analysis in the field of health could assist in priority setting and contribute

significantly 0to improving availability of non discriminatory programmes in health and to sex specific and gender sensitive health service development.

In terms of issues of immediate and obvious importance to women, the Committee might consider calling for attention to ways and means of addressing the challenge presented by the persistence of high maternal mortality rates even though pre-natal care reaches most women and most births are attended by trained personnel. In the context of information gathering on this issue consideration might be given to the role which could be played by young mothers, activists in women's organizations, religious and community leaders as sources of information as well as professional health care providers.

It is of deep concern that in 1997 44% of sex workers were reported to be HIV+. This needs immediate attention both in terms of the care, treatment, and service available to those women and in terms of the health and welfare of the whole population of Guyana. The Committee, therefore, might wish to ask the State Party for full information about their response to this evidence of AIDS in the population. In particular, it might be useful to inquire about AIDS education and training for adolescents and activity directed to the motivation and empowerment of sexually active men and women to behave responsibly, fairly, and in ways to protect their own health, that of future sex partners and children that might be born to them in the future.

NICARAGUA

Basic indicators

Nicaragua has a population of 5 million with a ratio of women to men of 101.100[18]. Life expectancy at birth is 71 years for women and 66 for men[19]. The population is growing at a rate of 2.7% per annum[20]. Urbanisation is high with 63% of the population living in urban areas. The urban growth rate is 4% per year[21]. Economically, the country falls in the low income category[22].

Children

43% of the population are children under the age of 15, about one third of them being under 5 years of age[23]. The infant mortality rates for the period 1995-2000 were 38 and 49 per thousand live births for girls and boys respectively[24]. Child (< 5) mortality was 48 per 1,000 live births in 1998, a decline from 193 in 1960[25]. Immunisation rates were variable -- 96% for TB, 69% for DPT, 73% for polio and 71% for measles in 1995-1998[26]. UNICEF data in 2000 reports 2% of children under 5 years of age are severely underweight[27].

HIV/AIDS is an emerging problem, although children below 15 years living with HIV/AIDS numbered less than 100. 520 children have lost either their mother or both parents to AIDS since the beginning of the epidemic[28].

Education shows no conspicuous patterns of discrimination at primary level with the enrolment ratio being 112 for girls and 109 for boys[29].

Adolescents

24% of the population of Nicaragua are aged 10-19 years[30]. During the period 1995-2000 for every 1000 young women aged 15 - 19, 152 babies were born[31]. At the end of 1999 the estimated proportion of 15-24 year-olds living with HIV/AIDS was 0.06% and 0.2% for women and men respectively[32].

Women

In 1990 28% of households were headed by women[33]. The fertility rate which, in 1960 stood at 7.3 had declined by 1998 to 4.4[34]. 71% of pregnant women received prenatal care and 65% of deliveries in 1990-1999 were attended by trained health personnel[35]. Nonetheless, UNICEF (2000) reports the maternal mortality ratio remains high at 150 per 100,000 live births[36].

At the end of 1999 an estimated 4,800 adults aged 15-49 HIV/AIDS[37]. 1,200 of them women. Violence against women is a major problem. In 1997 some 30.2% in Managua, the capital city, reported having been physically assaulted by an intimate partner in the previous 12 months[38].

Illiteracy among the 15 - 24 age group stands at 5.2% for women and 4.6% for men[39].

Older/ elderly women

In the year 2000 5% of the population over aged 60 were women, 4% men[40]. The ratio of women to men in this age group was 120:100, rising to 175:100 after the age of 80. Life expectancy at 60 is 20 for women and 18 for men[41].

Conclusion/ Comment

Violence against women stands out as a critical issue with serious implications for women's mental and physical health.

At the same time, the general absence of data disaggregated by sex makes it difficult to evaluate the degree to which discrimination against girls and women or the special circumstances of gender roles may make their specific situation even worse than suggested by available data. In view of this the Committee might wish to ask questions about the Government's overall data collection, analysis and planning system including in the field of health including non reproductive health issues, infectious diseases, malnutrition, cardio vascular disease, violence against women etc. Special attention

might be recommended to the situation of women of marginal groups and particularly vulnerable women and girls (including older women and adolescent girls). Availability of disaggregated data and regular gender analysis in the field of health could assist in priority setting and contribute significantly to improving availability of non discriminatory programmes in health and to sex specific and gender sensitive health service development.

43% of the population of Nicaragua is below the age of 15 years. Urbanisation is high (63%) and still proceeding at 4 % per year. Furthermore the country is identified as a low-income country by the World Bank (< US$ 760 per capita). This combination of youth, low income and high urbanisation carries serious risks for the mental and physical health of women. Gender based violence is often common. Women and girls are often exposed to the abuse and exploitation of trafficking. Smoking, drugs and prostitution are frequent threats to the health and life of girls and woman, particularly the poor. For physiological reasons, health problems related to the air pollution shared by all can be particularly serious for women. And regrettably, pregnant women can share with the foetus they carry, the negative effects of the pollution. For all these reasons the Committee might wish to raise a number of issues related to the health of poor urban women and their access to sex-specific, woman friendly information, care, treatment and service to meet the range of health needs typical of the life of poor urban women. Particular attention should also be given to the special needs of particularly vulnerable women such as the elderly, women heading households, women of marginal groups etc.

VIET NAM

Basic indicators

Viet Nam has a population of 8 million people with a ratio of 102:100 women and men[42]. Life expectancy at birth is 70 for women and 65 for men[43]. The population is growing at 1.6% per year overall. However, urban growth is higher, at 3.5% per year. Overall, a total of 21% of the population is urban[44]. Per capital GNP, at $330 places the country in the low-income category[45].

Children

Viet Nam is a young country with 33% of the population are children under the age of 15[46]. One third of these are under 5. The infant mortality rate (1995-2000) was estimated at 38 per thousand live births for both girls and boys[47]. There has been a significant reduction from 219 in 1960 to 31 in 1998[48]. Immunisation coverage is good at 98% for TB, 96% for DPT, 96% for polio and 89% for measles[49]. 9% of children below 5 years are reported to be "severely" underweight[50].

HIV/AIDS affected 2,500 children under 15 by the end of 1999 and 3,200 were said to have lost their mother or both parents to AIDS since the beginning of the epidemic[51].

Gross primary school enrolment ratio in 1990-1997 was 100 for girls and 106 for boys, the equivalent figures for secondary school enrolment (up to 1996) being 41 and 44 respectively[52].

Adolescents

22% of the population in 2000 were aged 10-19 years[53]. There was no complete data on the main health problems, but HIV/AIDS was reported to affect 0.1% and 0.3% of girls and boys respectively of those aged 15-24 years[54].

Women

Major health problems affecting women are related to reproductive function. The contraceptive prevalence of 75%[55] has contributed to a reduction in total fertility from 6.1 per woman in 1960 to 2.6 in 1998[56]. Although 78% of pregnant women received prenatal care and 77% of deliveries were attended by trained personnel[57], maternal mortality ratio remained high at 160 per 100,000 live births[58]. Disaggregated data is difficult to find on non reproductive health issues for example cardio vascular diseases, smoking, tuberculosis, disabilities.

The estimated number of adults (15-49) with HIV/AIDS was 99,000 by the end of 1999, an adult rate of 0.24%, of whom 20,000 were women[59]. Sex workers made a large contribution to the latter figure, as 6% of them were said to be infected.

Illiterate persons constituted 6.6% of women and 5.9% of men aged 15-24; corresponding figures for those over 25 were 22.1 and 7.6 respectively[60].

Older/ Ageing women

The population over 60 was 9% women and 6% men[61]. The ratio of women to men in this age group was 145:100, rising to 262 over the age of 80. Life expectancy at 60 was 20 for women and 16 for men[62].

Conclusion/ Comment

In spite of the low economic status, Viet Nam scores well in health and education equality, but reproductive morbidity and the emergence of HIV/AIDS will need to be addressed. However, data on non reproductive health issues is not easily available. In this connection, the Committee might wish to ask questions about the Government's overall data collection, analysis and planning system including in the field of health. Special attention might be recommended to the situation of women of marginal groups and particularly vulnerable women and girls, for example adolescent girls and older/ elderly women. Availability of disaggregated data and regular gender analysis in the field of health could assist in priority setting and contribute significantly to improving availability of non discriminatory programmes in health and to sex specific and gender sensitive health service development.

Particular attention might be directed to the situation of children, with special reference to the needs of the girl child. The data on both malnutrition and HIV/ AIDS indicate a need for immediate action if long term problems are to be avoided. In this connection the Committee might wish to ask about government response to the rising threat of HIV among adolescents and call attention to the particular threat to girls and young women.

With reference to the high per cent of urban dwellers, the Committee might consider asking about government response to common urban health problems such as those associated with urban air pollution, violence against women, occupation-related health problems, and urban poverty and their particular impacts on women and girls. In all cases, sex specific differentials which might arise from differences in exposure, vulnerability or access to information/ treatment should be investigated.

Given the ratio of women to men, particularly in the older age groups it would be useful to direct special attention to the mental and physical health of older women, particularly those who are widowed, functioning as heads of households or living on their own. Their special needs should be identified and dealt with in appropriate, accessible, woman friendly services.

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